Member Appeals and Grievances

The following topics are included in this chapter:

Members have the right to file a complaint if they have concerns or problems related to their coverage or care. Appeals and grievances are two different types of member complaints, as defined in the Parts C & D Enrollee Grievances, Organization/Determinations, and Appeals Guidance. For additional guidance pertinent to Tufts Health Plan SCO, an applicable integrated plan, refer to the Addendum to the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance for Applicable Integrated Plans. Appeals are intended to review an adverse organization determination for health care services and/or an adverse coverage determination for drugs that the member feels they are entitled to. Grievances are intended to address concerns or problems members have with their coverage or care.

Quality Improvement Organizations

Quality improvement organizations (QIOs) are groups of health care professionals that monitor the quality of care provided to Medicare members enrolled in Medicare Advantage products with CMS, including Tufts Medicare Preferred/Tufts Health Plan SCO members. The Acentra Health review process is designed to help prevent any improper practices. This process is separate and distinct from the Tufts Health Plan grievance process.

Acentra Health Beneficiary and Family-Centered Care is the QIO (BFCC-QIO) for Massachusetts. Tufts Medicare Preferred and Tufts Health Plan SCO members concerned about the quality of care received may also file a complaint with Acentra Health at 888-319-8452.

In accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended by the Omnibus Budget Reconciliation Act (OBRA) of 1986, Tufts Health Plan participates in external reviews of its QI program for members enrolled in Tufts Medicare Preferred or Tufts Health Plan SCO plans. The responsibilities of each organization that conducts the external review of Tufts Medicare Preferred/Tufts Health Plan SCO are delineated in Tufts Health Plan's agreement with Acentra Health.

Acentra Health Contact Information

Acentra Health: BFCC-QIO Program
5201 West Kennedy Blvd. Suite 900, Tampa, FL 33609
Phone: 888-319-8452
TTY: 711
Fax: 844-878-7921
Web: www.acentraqio.com/

Acentra Health Reviews

Acentra Health maintains a review system to ensure that services provided to Medicare beneficiaries enrolled in Medicare health plans are of adequate quality across all settings. This review system addresses the following issues:

- Appropriateness of treatment
- Potential for under-utilization of services
- Accessibility to services
- Potential for premature discharge of patients
- Timeliness of services provided
- Appropriateness of the setting for the provision of services
- Appropriateness of the Medicare health plan's activities to coordinate care (e.g., adequacy of discharge planning and follow-up of abnormal diagnostic studies)

Acentra Health will notify Tufts Health Plan regarding issues that include results of Acentra Health review activities, unless otherwise specified in Acentra Health's agreement with CMS. These issues will be identified as quality of care concerns or documentation concerns.

Tufts Health Plan will be notified when an Acentra Health review indicates a quality problem regarding an out-of-plan emergency or urgently needed care that an out-of-plan hospital, SNF, or other health care facility provided to a member, and the problem is attributable to the institution. However, the quality problem identified with respect to these services will be attributed to the out-of-plan provider/practitioner, rather than to Tufts Health Plan.

Appeals

As defined in 42 CFR 422.561, 423.560, and 422.633, appeals and integrated appeals are procedures that deal with the review of adverse initial determinations and adverse integrated initial determinations made by Tufts Health Plan regarding health care services or benefits under Part C or D that the member believes they are entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the member) or on any amounts the member must pay for a service or drug defined in 42 CFR 422.566(b) and 423.566(b). These appeal procedures include the following:

- Tufts Health Plan reconsideration or redetermination (also referred to as a level 1 appeal)
- Reconsideration by an independent review entity (IRE) or the MassHealth Board of Hearing for SCO Medicaid-only members and SCO Dual members requesting Medicaid-only services
- Adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator
- Review by the Medicare Appeals Council (Council)
- Judicial review

Under Part C, a reconsideration is the first level in the appeals process, which involves the review of an adverse organization determination or an adverse integrated organization determination by Tufts Health Plan, the evidence and findings upon which it was based, and any other evidence submitted by a party to the organization determination, Tufts Health Plan or CMS.

Under Part D, a redetermination is the first level in the Part D appeal process in which the plan sponsor reviews an adverse Part D coverage determination or at-risk redetermination, including the findings upon which the decision was based and any other evidence submitted or obtained.

Note: Tufts Health Plan and its network providers must not treat members unfairly or discriminate against them because they initiate an appeal or complaint.

Fast-Track Appeals

A fast-track appeal is appropriate when the member disagrees with the coverage termination decision from a skilled nursing facility (SNF), home health agency (HHA), or comprehensive outpatient rehabilitation facility (CORF), or upon notification of discharge for an inpatient hospital stay.

To initiate a fast-track review, the member must submit a fast-track appeal request within the required time frame to Acentra Health. Once an appeal is filed, beneficiaries remain entitled to continuation of coverage for their inpatient hospital stay, SNFs, HHAs, or CORFs until Acentra Health renders a decision. Acentra Health may be contacted by the member (or member's representative), attorney, or court-appointed guardian. Acentra Health is authorized by Medicare to review the services noted above provided to Tufts Medicare Preferred/Tufts Health Plan SCO members.

The provider must submit a copy of the important message (IM) or Notice of Medicare Noncoverage (NOMNC) and documentation from the medical record supporting the member's discharge from services to Acentra Health. Submission of these documents is a condition of payment and failure to submit these upon request may result in a claim denial.

The following documentation supporting the member's discharge from the current level of services is required:

1. Valid IM/NOMNC
2. At a minimum, the medical record must include **all the following:**
    a. An attending practitioner's (e.g., MD or NP) progress note, written within two calendar days of delivery of IM/NOMNC and including **all the following:**
        i. A statement that the member's current condition is stable and they are ready for discharge
        ii. A statement that the member no longer requires or will benefit from current level of services
        iii. An outline of the member's discharge plan: where member will be discharged to and what the transition of care plan is
        iv. A statement that addresses any open medical issues and how they will be managed
    b. Attending practitioner's order to discharge member from the current level of services, documented in the medical record by the date that the IM/NOMNC is issued
    c. A progress note from each applicable rehabilitation service (physical, occupational, and/or speech therapy) describing the member's current functional level, stability of their medical condition and a description of the discharge plan including any treatments to be carried out after discharge

If Acentra Health agrees with the member and overturns the decision to discharge, the member will be reinstated. The process recommences if/when the member is ready to be discharged again.

Tufts Health Plan monitors compliance with the time frame associated with Acentra Health hospital discharge appeals.

If the member misses the Acentra Health deadline to file a fast-track appeal for an inpatient hospital discharge (up until the day of discharge), they have the right to call Senior Products Member Services to request an expedited appeal. Tufts Health Plan generally makes a decision within 72 hours. During the fast-track appeals process, the member may not be held financially responsible for coverage of the requested services until an appeal determination has been made by Acentra Health.

Standard and Expedited Appeals

A member (or provider acting on the member's behalf) may appeal any adverse organization determinations or coverage determinations they believe they are entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the member), or any amounts the member must pay for. These appeals can include hospital discharge decisions, as well as SNF/HHA/CORF discharge decisions if the member missed the QIO (Acentra Health) deadline.

The following procedures apply to both Tufts Health Plan SCO dual eligible members and Medicaid-only members, with a few exceptions. The additional levels of appeal available to Tufts Health Plan SCO members include the independent review entity reconsideration.

Note: The ALJ hearing, MAC review and the judicial review are only available to dual eligible members, but not available to the Medicaid-only members. For Medicaid covered services, members have an additional right to appeal to the MassHealth Board of Hearings (see below).

The following procedures include reconsideration by Tufts Health Plan and, if necessary, the IRE (MAXIMUS Federal Services, Inc. and C2C Innovative Solutions, Inc.), hearings before a Social Security Administration ALJ, review by the MAC, and judicial review, as well as hearings at the MassHealth BOH.

Standard Member Appeals

In most cases, the organization determination and coverage determinations are final unless a member contacts Tufts Health Plan within 65 calendar days of receiving the determination (or longer if there is a reason for a good cause extension). If a member requests reconsideration (appeal) of a denial, Tufts Health Plan follows the standard member appeals procedure below. The appeal procedure takes place after the adverse organization determination has been issued by Tufts Health Plan.

Appeals Procedure for Part C Services

1. The member submits a written request for reconsideration to the Appeals and Grievances Department or a verbal request through the Senior Products Member Relations Department. For preservice requests, the treating provider may also request an appeal verbally or in writing without being appointed as the member's representative as long as the provider notifies the member the provider is filing the appeal. For post-service requests, the provider must be appointed as the member's representative.
    a. The Appeals and Grievances Department receives and reviews the appeal and, if needed, will request additional documentation.
    b. The member can identify an Appointment of Representative (AOR) as an authorized representative to act on their behalf during the appeal process. If the member does have an AOR or activated health care proxy, all correspondence regarding the appeal must be sent to the AOR and a copy may be sent to the member.
    c. For a request for a medical item or service, the Appeals and Grievances Department consults with other Tufts Health Plan departments, when appropriate, and completes the investigation and notifies the member as expeditiously as the member's health condition requires, not exceeding 30 calendar days (preservice requests) from the date the reconsideration request was received (or no later than upon expiration of a 14 calendar-day extension), regardless of whether or not the organization determination was overturned.
        i. If the request is for a Medicare Part B prescription drug, the Appeals and Grievances Department will complete the investigation and notify the member as expeditiously as the member's health condition requires, but not exceeding seven calendar days (preservice requests) from the date the request was received. The review time frame for Part B drug requests will not be extended. Post service requests will be resolved within 60 calendar days from the date the reconsideration request was received.
    d. For Tufts Health Plan SCO members, all medical necessity decisions will be made by a physician that was not involved in making the initial decision and not a subordinate of the original reviewer, has expertise that is appropriate for the service in question, and knowledge of Medicare and Medicaid coverage criteria. The Appeals and Grievances Department completes the investigation and notifies the member as expeditiously as the member's health condition requires, not exceeding 30 calendar days for either preservice or post-service requests from the date the reconsideration request was received (or no later than upon expiration of a 14 calendar-day extension), regardless of whether or not the organization determination was overturned. If the request is for a Medicare Part B prescription drug, the department will notify the member as expeditiously as the member's health condition requires, but not exceeding seven calendar days (preservice requests) from the date the request was received.

2. Tufts Health Plan may extend a preservice review time frame for a medical service or supply up to 14 calendar days if the extension is requested by the member, or if Tufts Health Plan determines that additional information is necessary and the delay is in the best interest of the member (e.g., additional diagnostic testing or consultation with medical specialists). Lack of availability of plan provider medical records is not considered an acceptable reason for delay. The review time frame for requests for Medicare Part B prescription drugs will not be extended. Tufts Health Plan may extend the SCO pre- and post-service review time frame up to 14 calendar days for the reasons stated above.
3. If the organization determination was not overturned, the appeal denial notice informs the member that all relevant information was forwarded to the CMS reconsideration contractor, MAXIMUS Federal Services, Inc.

   Note: Forwarding an appeal to MAXIMUS Federal Services, Inc. does not apply to SCO Medicaid-only members or to SCO Dual members (dually eligible for both Medicare and Medicaid) requesting Medicaid-only covered services. SCO Medicaid-only members and SCO Dual members requesting a Medicaid-only covered service have external appeal rights through the MassHealth Board of Hearing. The written notification letter includes the external appeal rights as well as the right to request and receive Medicaid-covered benefits while the next level of appeal is pending, if applicable.

Appeals Procedure for Part D Services

1. The member sends a written request for reconsideration to the Appeals and Grievances Department or a verbal request through Senior Products Member Relations at 800-701-9000. For preservice requests, the prescribing provider may also request an appeal verbally or in writing without being appointed as the member's representative, as long as the provider notifies the member that they are filing the appeal on the member's behalf.
   a. The Appeals and Grievances Department receives and reviews the appeal and, if needed, requests additional documentation.
   b. The member may identify an AOR to act on their behalf during the appeal process. If the member does have an AOR or activated health care proxy, all correspondence regarding the appeal must be sent to the AOR and a copy may be sent to the member.
   c. The Appeals and Grievances Department consults with other Tufts Health Plan departments when appropriate and completes the investigation as expeditiously as the member's health condition requires, not exceeding seven calendar days from the date the redetermination request was received for pre-service requests. Requests for reimbursement are completed within 14 calendar days from the date the redetermination request was received and if the original denial is overturned, the check will be issued within 30 days.
2. Tufts Health Plan may not extend the review time frame for Part D appeals or requests for a Medicare Part B prescription drug.
3. If the coverage determination was not overturned, the appeal denial notice informs the member of the right to submit a reconsideration request to C2C Innovative Solutions, Inc. Included with the decision notice is a Request for Reconsideration notice for the member to send to C2C Innovative Solutions, Inc.

Expedited Appeals

An expedited appeal is a review of a time-sensitive adverse organization determination, coverage determination, or at-risk determination that a member believes that they are entitled to receive, including:

- Any delay in providing, arranging for, or approving health care services/medications that would adversely affect the health of the member
- Reduction or stoppage of treatment or services that would adversely affect the member's health

Note: Time-sensitive is defined as a situation in which applying the standard decision time frame could seriously jeopardize a member's life, health, or ability to regain maximum function.

Members, their representatives, or any treating or prescribing physician (regardless of whether the provider is affiliated with Tufts Health Plan) can request an expedited appeal. Verbal and written requests for expedited appeals are accepted. If the request meets the necessary time-sensitive criteria, a decision will be made within 72 hours of receipt of the request, unless an extension is needed. Extensions of up to 14 calendar days can be granted if in the best interest of the member.

Note: Extensions are not allowed for expedited Part D appeals or requests for a Medicare Part B prescription drug.

Providers may access appeals information on the CMS website as well as at the following links:

- Medicare Managed Care Appeals and Grievances
- Beneficiary Notices Initiative (BNI)
- Advance Notice Form Instructions

Independent Review Entity (IRE) Review and Additional Appeal Levels

1. MAXIMUS Federal Services, Inc. and C2C Innovative Solutions, Inc are the IREs that review the information provided by Tufts Health Plan and requests any additional documentation needed from either Tufts Health Plan or the member. MAXIMUS Federal Services, Inc. and C2C Innovative Solutions, Inc. are separate entities from Acentra Health.
2. MAXIMUS Federal Services, Inc. and C2C Innovative Solutions Inc's reconsideration determination is final and binding, unless a request for a hearing before an ALJ is filed within 60 calendar days of receiving the reconsideration notice.
3. Any member may request a judicial review (after notifying other parties) of an ALJ decision, if the amount in controversy meets the appropriate threshold (new thresholds are published by CMS every fall) and the Medicare Appeals Council (MAC) has denied the member's request for review.
4. Any decision by Tufts Health Plan, MAXIMUS Federal Services, Inc, C2C Innovative Solutions, Inc, the ALJ, or the MAC may be reopened within 12 months or within four years for good cause. Once a revised determination or decision is issued, any party may file an appeal.

Executive Office of Health and Human Services Board of Hearings (EOHHS BOH)

Upon receipt of a written notice of Tufts Health Plan's decision to deny, terminate, or reduce services, both Tufts Health Plan SCO dual members and Medicaid-only members may file an internal appeal. If the internal appeal decision upholds the original service denial, members may request an external review by the Board of Hearings (BOH). The BOH will render a final decision within the time limits specified under MassHealth's Fair Hearing Rules (130 CMR 610.000). Pursuant to 130 CMR 610.016, if a member elects a provider to be their appeal representative, the provider may request a BOH review of Tufts Health Plan's internal appeal decision to uphold the initial decision to deny, terminate, suspend, or reduce services.

The member must submit a request for a BOH appeal, in writing, no later than 120 calendar days from the date of mailing of Tufts Health Plan's internal appeal decision.

A member can choose to continue receiving requested services from Tufts Health Plan during the BOH appeal process. If the member wants to receive such continuing services, the member or their authorized appeal representative must submit the BOH appeal request within ten calendar days from the date of the internal appeal denial letter and indicate that they want to continue to get these services.

If the BOH decides in the member's favor, Tufts Health Plan must authorize or provide the service in dispute as expeditiously as the member's health condition requires but no later than 72 hours from the date Tufts Health Plan receives the notice of the BOH decision. If the outcome of the BOH external review upholds Tufts Health Plan decision, the member will not be financially responsible for the services provided during the review period. If Tufts Health Plan or the member disagrees with the BOH decision, there are further levels of appeal available, including judicial review of the decision under M.G.L. c. 30A. Tufts Health Plan must comply with any final decision upon judicial review.

Grievances

A grievance is an expression of dissatisfaction with any aspect of the operations, activities, or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. A grievance does not include, and is distinct from, a dispute of the appeal of an organization determination or coverage determination or an LEP determination.

In addition, grievances may include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided health service, procedure, or item. Grievance issues may also include complaints that a covered health service procedure or item during a course of treatment did not meet accepted standards for delivery of health care.

Grievance Procedure

Per regulatory guidelines, Tufts Health Plan has established a forum for members or authorized representatives to express concerns regarding their experiences with health care providers. The member grievance procedure, allows for the documentation and review of member complaints, as follows:

1. Upon receipt of a verbal or written complaint, the grievance analyst acknowledges either verbally or in writing that the complaint was received and will be reviewed within 30 calendar days (or within 24 hours if the grievance is expedited). The Appeals and Grievances department can accept any information or evidence concerning the grievance orally or in writing.
2. In most instances, providers or their office managers (depending on the specific situation) are notified either verbally or in writing about the complaint and asked for input.
3. If the complaint pertains to a quality of care issue (clinical grievance), the QM RN Specialist evaluates the information. The clinical grievance is assigned a severity and preventability rating related to the issue or concern. The provider is notified of the results of the quality review. All grievances and their respective ratings are entered into our secured quality database for tracking and trending purposes. This data becomes part of the provider's credentialing file and is reviewed periodically.

It is the member's responsibility to notify Tufts Health Plan of concerns about their health care services. It is the responsibility of all network providers to participate in our grievance review process.

Providers are expected to respond to a request for information within five business days, as it is standard for providers to respond to the plan's request for information in investigating member grievances. This turnaround time is required to ensure that the plan meets its regulatory and accreditation requirements to the member and remains compliant with all state and federal requirements.

PUBLICATION HISTORY
06/01/25 Updated KEPRO with Acentra Health; updated Standard Member Appeals section; administrative edits.